DENVILLE DIAGNOSTICS

MRI Patient Information: [ ] Male [ ] Female

Patient Name: _____ Date of Birth: ____/____/_____ SS#: _____
Mailing Address: _____ City: _____ State: _____Zip: _____
Phone #'s: (Home) _____ (Work) _____ (Cell) _____

Referring Physician: _____ Phone #: _____/Fax#: _____
Additional Physician: _____ Phone #: _____/Fax#: _____

Primary Insurance Information
Insurance Company Name: _____
Insurance Group #: _____ Insurance ID#: _____
Are you the primary insurance carrier? YES NO
If **NO**, please fill out the following information:
Name of Primary Insurance carrier: _____ Relationship to Patient: _____
Date of Birth: ____/____/_____ Primary Insurers SS#: _____ Phone #: _____

Secondary Insurance Information
Insurance Company Name: _____
Insurance Group #: _____ Insurance ID#: _____
Are you the secondary insurance carrier? YES NO
If **NO**, please fill out the following information:
Name of Secondary Insurance carrier: _____Relationship to Patient: _____
Secondary Insurers Date of Birth: ____/____/_____ Secondary Insurers SS#: _____ Phone #: _____

In the event of an emergency, please contact:
Name: _____ Relationship: _____ Phone #: _____

Why is your referring physician requesting that you have this exam? _____
Is there any possibility of pregnancy? YES NO
Do you have a pacemaker? YES NO ***(If, YES – STOP! This patient cannot have an MRI)***
Do you have aneurysm clips? YES NO
Have you had any previous surgery to the location in which we will be scanning? YES NO
If YES, please list the type of surgery and the procedure date: _____
Do you have medical implants of ANY type? YES NO
What type of implants? _____
Have you ever been diagnosed with cancer? YES NO
If YES, please list the type and form of treatment: _____
Do you or have you had **any** incidental or prolonged exposure to metal or the metal industries due to employment, an accident or for any other reason? YES NO
If answered YES, please explain: _____
Have you had an orbital x-ray for MRI clearance? YES NO
Have you had any relevant x-rays or other testing done prior to today's exam? YES NO
If YES, when and where were the prior tests performed and what were the results? _____
Do you have asthma? YES NO
Do you have any kidney disease or dysfunction? YES NO
Do you have diabetes? YES NO
If YES, what diabetes medications are you currently taking? _____
Which doctor manages your diabetes? _____ Phone #: _____

I attest that the above information is correct and true to the best of my knowledge. I have read and understood the entire contents of this form and have had the opportunity to ask questions regarding its requested information.

Signature (Patient or Legal Guardian): _____ Date: _____

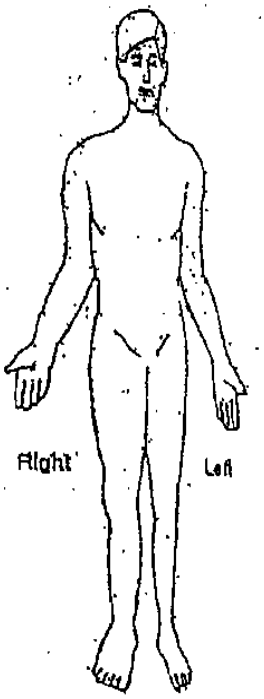
DENVILLE DIAGNOSTICS

THE FOLLOWING ITEMS MAY BE HAZARDOUS OR MAY INTERFERE WITH THE MRI EXAMINATION BY PRODUCING AN ARTIFACT

PLEASE INDICATE IF YOU ANY OF THE FOLLOWING:

YES	NO	
____	____	Cardiac Pacemaker
____	____	Aneurysm Clip(s)
____	____	Implanted cardiac defibrillator
____	____	Neurostimulator
____	____	Any type of biostimulator
		Type:_____
____	____	Any type of internal electrode(s), including:
		Pacing wires
		Cochlear implant
		Other:_____
____	____	Implanted Insulin pump
____	____	Swan-Ganz catheter
____	____	Halo vest or metallic cervical fixation devices
____	____	Any type of electronic, mechanical, or magnetic implant
		Type:_____
____	____	Hearing Aid
____	____	Any type of intravascular coil, filter, or stent
		(e.g., Gianturco coil, Gunther IVC filter, Palmaz stent, etc.)
____	____	Implanted drug infusion device
____	____	Any type of foreign body, shrapnel, or bullet
____	____	Heart valve prosthesis
____	____	Any type of ear implant
____	____	Penile Prosthesis
____	____	Orbital/eye Prosthesis
____	____	Any type of implant held in place by a magnet
____	____	Any type of surgical clip or staple(s)
____	____	Vascular access port
____	____	Intraventricular shunt
____	____	Artificial limb or joint
____	____	Dentures
____	____	Diaphragm
____	____	IUD
____	____	Pessary
____	____	Wire mesh
____	____	Any implanted orthopedic item(s) (e.g., pins, rods, screws, nails, clips, plates, wire, etc.)
		Type:_____
____	____	Any other implanted item
		Type:_____
____	____	Tattooed eyeliner*

Please mark on the drawing the location of any metal inside your body.



*A small percentage of patients with tattooed eyeliner have experienced transient skin irritation in association with MRI. Therefore, you must decide if this slight risk warrants undergoing your examination. You may want to discuss this matter with your referring physician.

I attest that the above information is correct to the best of my knowledge. I have read and understood the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient's Signature_____

RT Signature_____ Date_____

RT Name_____

DENVILLE DIAGNOSTICS

Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patients' consent for uses and disclosures of Health Information about the patient to carry out treatment, payment or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical and will do all that we can to secure and protect your privacy. When it is appropriate and necessary we provide the minimum necessary information to only those we feel are in need of our healthcare information and information about your treatment, payment or healthcare operations, in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for the purpose of treatment, payments, or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refusal of all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patients Name: _____

Signature of Patient and/or Legal Guardian: _____

Date: _____/_____/_____

DENVILLE DIAGNOSTICS

PATIENT BILL OF RIGHTS

Each patient receiving service's in our facility shall have the following rights:

1. To be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient could understand. The facility shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility.

2. To be informed of services available in the facility names and professional status of personnel providing patient's care, and of fees and related charges, including payment fee, deposit and refund policy of the facility and any charges for services not covered by sources of third party payment or not covered by the facility's basic rate.

3. To be informed if the facility has authorized other health care and educational institution to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions and to refuse to allow their participation in the patient's treatment.

4. To receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his/her complete medical health condition or diagnosis, recommended treatments, treatment option, including the option of no treatment, risk(s) of treatment, and expected result(s). If this information would be detrimental to the patient's health or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record.

5. To participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record.

6. To be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law rule and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices.

7. To voice grievances or recommend changes in policies and services to facility personnel, the governing authority and/or outside representatives of the patient's choice either individually or as a group and free from restraint, interference, coercion, discrimination or reprisal.

8. To be free from mental and physical abuse, free from exploitation and free from use of restraints unless they are authorized by the physician for a limited period of time to protect the patient or others from injury. Drugs or other medications shall not be used for discipline of patients or for convenience of facility personnel.

9. To confidential treatment of information about the patient. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another healthcare facility to which the patient was transferred required the information, or unless the release of the information is required and permitted by law, a third party payment contract, a peer review or unless the information is needed by the NJ State Department of Health for statutory authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked.

10. To be treated with courtesy, consideration, respect and recognition of the patient's dignity, individuality, and the right to privacy, including but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when the facility personnel are discussing the patient.

11. To not be required to perform work for the facility unless work is part of the patient's treatment and the work is performed voluntarily by the patient. Such work shall be in accordance with local, state and federal laws and rules.

12. To exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices or any attendance at religious services shall be imposed upon the patient.

13. To not be discriminated against because of age, race, religion, sex, nationality, ability to pay, or be deprived of any constitutional, civil and/or legal right solely because of receiving services.

Sign_____**Date**_____

DENVILLE DIAGNOSTICS

Insurance Consent Form

By signing this form, I am verifying that all of my insurance information is valid and up to date.

The insurance cards given to this facility are current and active cards and the proper information has been given in regards to the insurance holder's information, for example: Name, DOB, and/or Social Security Number.

By signing this form, I am verifying that the proper actions were performed in regards to obtaining an authorization number, pre-certification number, and/or referral.

I understand that if an authorization number, pre-certification number, and/or referral was needed in order to have the exam and was not obtained before the time of service that I will be held responsible for the balance of the bill if the insurance company denies the claim.

I confirm that I have read over all of the above information and I believe everything to be true to the best of my knowledge.

Patients Name: _____

Signature of Patient and/or Legal Guardian: _____

Date: _____/_____/_____